

*This is an interview with Dr. Jack Whitescarver, Deputy Director of the Office of AIDS Research (OAR) at the National Institutes of Health (NIH), in Bethesda, Maryland, on April 18, 1990. The interviewers are Dennis Rodrigues, Program Analyst, and Dr. Victoria Harden, Director of the NIH Historical Office.*

Rodrigues: As some background information, could you tell us why you became interested in a career in biomedical research?

Whitescarver: I've always had a curious mind. I never thought of any other profession except biomedical research since my high school days, and so I pursued it. Right out of college I became involved in cancer research, and that led to virology, followed by the broader study of obligate intracellular parasites. To make a long story short, I jumped in the middle of a snowstorm from the Harvard School of Public Health and rickettsia to the NIH and the Grants Associates Program.

Rodrigues: When did you come to the Grants Associates Program?

Whitescarver: I came to the Grants Associate Program in 1977. My first appointment at the NIH was as special assistant to the director of the National Institute of Allergy and Infectious Diseases (NIAID), who then was Dr. [Richard] Krause.

Rodrigues: What were some of the issues and problems that you were working on in the late 1970s, before the Pneumocystis [Pneumocystis carinii pneumonia, PCP] and Kaposi's [sarcoma] cases started to appear on the scene? What were some of the things that you were involved in?

Whitescarver: My primary responsibility was to be the liaison between the NIAID and the private, public, and professional organizations that had interest in the programs of the NIAID. The NIAID, historically, had virtually no grass-roots support. It was my job to go out and engender interest among these groups to support the programs of the NIAID and to develop committees that would advise the NIAID on programmatic areas of emphasis. I was also the aide-de-camp to Krause; I got involved in virtually everything from the point of view of policy. But my first and foremost responsibility was dealing with constituent groups.

Harden: Could you elaborate on some of these groups? Were these particular infectious disease groups?

Whitescarver: Yes. We covered the whole gamut of the research efforts of allergy, immunology, and infectious diseases, so we were involved with the American Society for Microbiology (ASM), the American Academy of Allergy and Immunology, the Infectious Disease Society, the Lupus

Society of America, the American Social Health Association, and a myriad of other organizations that really didn't know much about the NIAID—except for the ASM, which knew a lot about NIH and NIAID.

Harden: What did you want them to do with you?

Whitescarver: We wanted a strong constituency base that could speak about the needs of the Institute to the Congress. The Heart Institute [National Heart, Lung and Blood Institute, NHLBI] made strides because of the strong support of the American Heart Association. With their politically sensitive committees and spokespersons, they had people who would speak to the Congress on behalf of the Heart Institute. The Cancer Institute [National Cancer Institute, NCI], with support from the American Cancer Society, had the same advantage. There was no society for allergy or infectious diseases that had any clout.

Harden: I guess the lack of public awareness about infectious diseases was a problem.

Whitescarver: That's correct, and that was one of Krause's goals: to popularize, to show that infectious diseases, allergy, and immunology are very important areas. In fact, his testimony to the Congress went along the lines of educating people that an infectious disease could crop up at any time, and that they always had historically. Just because we had a battery of antibiotics didn't mean that we had the cure-all for every infectious disease. There were no antivirals, for example, and there were lots of viral diseases. In the hundred years since [Louis] Pasteur, only eleven vaccines had been developed, so there was a lot of work to be done. Allergy was becoming truly a science rather than a sub-specialty, because we knew more about immunologic diseases than before. It was being put on a very sound scientific base.

Rodrigues: One aspect of this relates to the growth of some of the other institutes. Looking at the opportunities that were coming along to further work in these other areas, it seemed as if NIAID was probably suffering more than some of the other institutes in terms of having the resources and being able to capitalize on these opportunities. This had a bearing, I think, on the degree to which they could move on new problems.

Whitescarver: Yes. In those days, the NIAID had the lowest payline of any of the institutes, and the lowest award rate. We kept preaching that the poor get poorer and the rich get richer with these percent increases. We were not able to keep up with scientific opportunities, particularly in the mushrooming area of immunology. We were afraid that we were going to lose a lot of the immunologists because we couldn't afford them. We

weren't about to let highly qualified, scientifically meritorious awards be held up in the NIAID that couldn't be paid. We would certainly release them to other institutes, but we didn't want to give away our whole portfolio. So, we had to have ways of getting more attention and money into the till. We had a broad area of responsibility, but not much flexibility.

Harden: This was also the time when some restructuring was being done in the intramural program of NIAID, was it not?

Whitescarver: Yes. Before I came on board with NIAID, Ken [Dr. Kenneth] Sell had been appointed as the scientific director, and he had reorganized the intramural program and instituted particular areas of emphasis. That's when Tony's [Dr. Anthony Fauci's] lab was established in immunoregulation. There was a lot of change going on, reflecting the scientific opportunities and the expertise of the NIAID. It was easier to recruit and to shore up scientific areas in those days than it is now.

Rodriguez: Do you recall when you first heard of these cases that became known as AIDS that were starting to be recognized on the west and the east coasts?

Whitescarver: I certainly was aware of the four cases on the west coast long before I knew anything about [Dr. Alvin] Friedman-Kien's work in New York on Kaposi's.

Harden: Could you discuss that meeting that you started to tell us about before this interview began? Was this the first time that there had been sort of an official meeting?

Whitescarver: This was a special site visit to the CIRID [Centers of Interdisciplinary Research on Immune Diseases] in Los Angeles at UCLA [University of California, Los Angeles]. The meeting's purpose was for a group of evaluators to look at the progress in this new program of an interdisciplinary center. Built in to each of these CIRIDs, by congressional mandate, was an outreach activity, so we had public people along on this site visit. The agenda that they gave us the night before was all about their progress in allergy and immunologically based diseases. The next morning, when we got to UCLA, they gave us another agenda, and I noticed that the primary difference was that they had added a presentation by [Dr.] Michael Gottlieb on Pneumocystis in these four male patients. I objected to that being put on the agenda because I didn't see the rationale of an infectious disease's being discussed as a part of the progress on allergy and immunology. But [Dr.] John Fahey said, "Well, now wait. Yes. it's an infectious disease, but it has a very interesting immunological profile to it." So we left it on, and Mike talked about the four patients—

two were homosexuals, one was a bisexual; those three had already died. The fourth was still living and had not admitted to being a homosexual.

This presentation was very curious to our group. The members didn't quite see how it fit in with what they were reviewing. There was a clinical allergist, a lawyer, and basic immunologists as well as clinicians. They didn't quite see why we were being told about this phenomenon, except that it was very curious that, in this disease entity, this Pneumocystis, the CD4s were down and the CD8s were way up—T4s and T8s. It was an interesting kind of observation that had not previously been noted in Pneumocystis patients, and it looked like the profile of an immune-deficient patient. These were young people, and none of them—even though their case history wasn't complete—had had any kind of disease or were taking any medication that would bring about this immune deficiency. I think that an infectious agent was suspected, but I'm not too clear on this. I think that the report might have it in it. I'm not so sure that John Fahey and Mike Gottlieb looked upon these particular Pneumocystis cases as opportunistic infections, like they saw in the cancer patients. Both of them have a lot of cancer patients. John Fahey, as you know, was in both areas, cancer research as well as basic immunology and clinical immunology. A footnote to this story is that some years later, the fourth person was identified as a Haitian. At that time, there was no reason to mention that this chap was a Haitian. It became a part of the report, however.

The cases posed an interesting immunological situation, and I remember talking about it to Mike. Given that Pneumocystis was opportunistic, I thought that if something was causing those T-4 cells to go down, or to change the normal immunological profile, we might have an infectious disease, and we certainly should be aware of that. So I came back to the NIAID and that was put in our report. It went down to the Congress, and we talked about it at the [NIAID] executive committee. It was not a special topic, but we talked about the review of the CIRIDs, which were kind of special to the NIAID because they were the first of the congressionally mandated activities. We knew that Congressman [George] O'Brien was particularly interested in them. So we all agreed that those four cases were very interesting; we must keep an eye on them. We weren't going to look further into them, however, because there seemed to be no real reason to pursue them dramatically.

Harden: It appeared to be an isolated situation?

Whitescarver: Yes. It just seems that we got involved gradually. I do remember we were talking about having to shift funds to support activities to look into this new disease entity, which appeared to be infectious and certainly had very

interesting scientific basis as far as immunology is concerned. Our first involvement was through Ken Sell, who immediately began to focus some research activities of the intramural program on the problem. Some intramural scientists began looking for the agent or agents, and their first thought was that it might have something to do with hepatitis, because all of these people had had hepatitis. Well, as it turned out, all those people had had everything else as well. That made us curious about whether the hepatitis vaccine had something in it. And, boy, did I get upset about that, because I'd been on a protocol over here—I had taken the hepatitis vaccine. I really got worried. Extramurally, things were much slower in getting started than intramurally. It was almost overnight that they started intramural research activities.

Harden: There's a considerable difference between how fast the intramural program can change and how fast the extramural program can change, isn't there?

Whitescarver: That's right. It takes a while for extramural. You've got to wait until applications come in. You can't just go out and direct activities. We've been criticized for being sluggish in getting started. I don't remember the exact date when the first patient was admitted, but I do recall that there was a snowstorm, and NIH was closed. It was right before an NIAID council meeting. Somehow I had gotten into work, and Krause was already in. We were the only two people on the seventh floor, and the telephones were ringing everywhere. I answered the phone at one point, and it was a physician from some area outside of Philadelphia. He said he had tried all over Washington—even the White House—but he couldn't get anybody. He needed some help, and he had tried everywhere. To this day, I don't know how he knew to call NIAID. He had a patient—a forty-odd year old man who had Pneumocystis, and he'd done everything he could do for him, but he was still very ill. Could we offer any advice? I said, "Well, I'm not a physician, but I'm sure we can offer you some advice. Hold on." I called Krause, who talked with the man. He told me to call Tony [Fauci]. Tony was also in, and the patient was later admitted that same day around six o'clock. That was, as I recall, the first AIDS patient admitted to the Clinical Center, and Tony took care of him.

Harden: Can you follow that case any further or is this pretty much where you left it?

Whitescarver: That's where I left it. I'm sure it can be tracked down.

Rodrigues: It's interesting the way things evolved. You mentioned that you got involved slowly, and that's consonant with the picture we see emerging from documents and other interviews. I think that it was the function of the particular interests in unusual diseases and background in immunology

of the various investigators, that led them to pick up quickly on these cases. Because of their professional and intellectual curiosity, they began pursuing it, and eventually, programs and organized efforts began to take form around those projects.

Whitescarver: You're absolutely right. That's how it got started extramurally as well. Grantees took money away from their ongoing projects if those projects were, in some respect, related to their new interest in this unusual disease. Cancer [NCI] got involved because of Kaposi's. In one of the first meetings we had—I can't remember the details, but it was a huge meeting—we didn't know much about what we were talking about. We were just trying to gather facts and to determine how to focus efforts. What would be the most important areas to pursue? This was before the agent was identified. Al [Dr. Albert] Sabin was the person who summed that meeting up. It would be interesting to get hold of the minutes of that meeting. We were looking for guidance on what we should be doing intramurally—where some things were already being done—and what we should be doing insofar as putting RFAs [Request for Applications] and program announcements out. We still did not have any special appropriation for these efforts.

Harden: What I'm trying to determine is the way in which a realization came into the institute's understanding that this was a larger problem than just a few isolated cases. Could you comment on that and talk about the mechanism of issuing RFAs and RFPs [Request for Proposals] versus principal investigators just writing in to say, "I want to do this" on the grant proposal?

Whitescarver: Dr. Krause has always been a very strong believer in investigator-initiated research, saying that the breakthroughs come from those novel efforts. That was going to go on whether or not there was any specific AIDS program. People who were interested in getting into AIDS would do it on their own just by sending in meritorious applications without any kind of RFA or RFP. There was early interest in doing some directed research by contract, particularly by those looking for the causative agent. Until one had that, one couldn't really do much of anything as far as therapeutics, without doing it shotgun style. Also, there was early interest in treating the opportunistic infections and in immune modulation. In order to do that, one had to focus on the most frequently observed opportunistic infections, and we did put RFAs out for candidiasis and some of the other rare diseases. In this country, infectious diseases certainly raised their ugly heads when it came to immunocompromised individuals. There were meetings pulled together on that issue as well. This was just to get RFAs out on it.

We were identifying the most obvious things that we needed to know at that point. We needed to find out what was causing it, whether it was an infectious disease, and what the predisposing factors were. We were still investigating whether co-factors predisposed the individual to infection. Another question was what specifically were they dying with? Because we saw that infectious diseases were killing most patients, we decided to attack from that arena, so research in that area made up much of the first targeted efforts.

Rodrigues: The records indicate that the first RFA was a joint one between NIAID and NCI. Did the fact that NCI was the first institute to start activity with the RFA create any problems in terms of defining the responsibilities between NIAID and NCI?

Whitescarver: No. The institutes worked together early on, because finances required it. We thought we could do more if we combined our efforts. Jack [Dr. John] Killen was with the Cancer Institute at that time, and I was with the Allergy Institute. We each sent an institute representative on these site visits, and there was cooperation from the very beginning on those early RFAs. We wanted some sort of control over the research, but nobody had any contract money. We decided to use the cooperative agreement mechanism, which could be funded out of the grant monies.

Harden: The topic of relations among the various institutions and agencies in government has received a lot of criticism in the popular press. How would you characterize the interchange of information and the cooperation among the CDC [Centers for Disease Control and Prevention], NIAID, NCI, FDA [Food and Drug Administration] and any other agencies like the PHS [Public Health Service], during the early years?

Whitescarver: There was no involvement of other PHS agencies outside of the CDC. The CDC was sluggish except for counting, but I wasn't involved in this, so I don't have the details. I do know that there was a bumpy road between the CDC and the NIAID on the Zaire project. That got started when the Belgians came to us and asked our help in setting up a research effort in Kinshasa. The international infectious disease group met in Vienna that year. Krause, Dr. Peter Piot, the Belgian minister of health, Tom [Dr. Thomas] Quinn and others met over lunch to discuss our research effort in Zaire. After that point, I was not involved. The state department had to get involved and, consequently, the CDC got involved. [Dr.] Jonathan Mann and [Dr. Joseph] McCormick were the representatives from CDC. The CDC then came on very strong as if they were going to take over, and that created a hell of a lot of problems in Zaire. It has survived beautifully, however. That was the first international effort. There was very little cooperation between agencies in the beginning of this. I don't know of

other agency involvement except the CDC and NIH.

Harden: Did this retard efforts?

Whitescarver: I think it probably slowed things down. Africa was going to be complicated anyway. But whether it was a significant slowing or not, I don't know.

Harden: Within the country, what could have been done with better cooperation?

Whitescarver: We probably would have been on site earlier, had there been better cooperation on this end. Since my job is at the NIH, I heard all the things that CDC was doing wrong. If you talked to the CDC, they'd probably tell you all the things that NIH was doing wrong. Nonetheless, one couldn't say, "Here's a beautiful example of cooperation between two agencies for the common goal." I don't think anybody would say that was the case. I don't think that would happen now. I'm quite convinced that it wouldn't happen now because of the high visibility. It wouldn't happen if any new disease came along and cut through the agencies. Agencies meet all the time now, and tell each other what they're doing. I just don't think it would happen now.

Rodrigues: I found some of the documents where NIAID was sponsoring some meetings with the Haitians and with other delegations coming here. Was that initiative initiated by the Haitians?

Whitescarver: Yes. It was initiated by the Haitians, who were looking for help. It became very sensitive. The minister of health and a few others came out here and told us about the way they saw the problem in Haiti, and then we sent a group down there. Krause headed the group that went down. Tom Quinn and some CDC people went as well. Nothing ever came of that like it did in Africa. But it certainly helped the Haitians out, and that finally led to declassifying Haitians as an "at-risk" group. It was the behavior of the Haitians that put them at risk. This was very difficult to undercover. They just wouldn't admit it.

Rodrigues: Jumping back a little bit, we were talking about the CIRIDs and how some of the work that was supported under those centers began to be sensitive to the emergence of AIDS. How about some of the other work that NIAID was doing in the sexually transmitted disease areas? Did those programs and activities eventually become integrated with the evolution of the AIDS program at NIAID?

Whitescarver: Because there was a great deal of interest in co-factors, a lot of proposed cofactors were studied under the STD [Sexually Transmitted Disease]

program. Also, the STD clinics, particularly among the gay and lesbian communities—I'm thinking specifically of Los Angeles—had support from other agencies. They invited NIAID people to come down and talk to the groups there in Los Angeles. Krause made one or two speeches; Ken Sell also went out there for some speeches. So, the STD program got linked to health care delivery, which, I guess, was funded by HRSA [Health Resources and Services Administration]. They looked for opportunities and research efforts with the individuals coming into the STD clinics where they were picking up a lot of AIDS.

Rodrigues: I would like to ask you about the political climate and its effect on the Institute's policies. There were several hearings taking place. [Theodore] Weiss had a hearing; Dr. Krause testified at that. There was a report, which came out some months later, that was primarily critical of the CDC, but it also mentioned NIH. Would you say that political activity was creating the pressure being felt, or was the pressure due to the fact that you had to wait for scientific knowledge to be able to move forward rationally or to expand the effort?

Whitescarver: Political pressures were certainly felt early on because Tim Westmoreland [congressional aide to Rep. Henry Waxman and chief counsel to the House Subcommittee on Health and the Environment]—I remember this vividly—called us to come down and talk to him about AIDS and what the NIAID's effort was in it. Krause and Sell went down to talk to Tim. It was interesting that both Dr. Sell and Dr. Krause talked about the overall NIAID effort in virology and immunology as basic research endeavors that would provide answers for dealing with the new disease. It did not suit Tim Westmoreland at all. Tim was very straightforward and made it quite clear that his impression of what they were telling him was that they were building a story of excuses for why they didn't have a more targeted effort toward AIDS. Krause's defense was that a lot of all the great scientific breakthroughs came from a free-ranging effort and this was what they were supporting. They were supporting the broad base of virology, with greater emphasis on STD research and immunology. But it was quite clear that this was not sufficient as far as Tim was concerned.

Harden: This was before the agents had been identified, so the target was still being looked for?

Whitescarver: Right. The agent was identified about the time I was leaving government. I think that the NIAID's position on that was, "This is terrific, but we need to confirm this. You do not make an all-out proclamation based on four papers." The NIAID took a conservative stand on the announcement and waited before it started developing any programs that involved the retrovirus that had been identified as the cause of AIDS.

Rodrigues: I thought it was interesting that in 1983, apparently, Dr. Krause met with several community groups concerned with AIDS.

Whitescarver: This is what I was talking about. At the time, Steve Shulte became quite an advocate, and then he became mayor of West Hollywood. He arranged for Krause to come out to the Gay and Lesbian Community Services Center and talk about AIDS. The NIAID picked up on it. We'd never done any outreach activities and had no mandate to do it. Therefore, we did not have a real, legal base for spending money in outreach activities. But we felt that it was terribly important to get information out. We targeted physicians, nurses and all para-professionals, as well as dentists, first. I started that program in the fall of 1983, I believe. The first meeting was in October, and we had a contract in place already. We used that contract to have the first meeting at Masur auditorium on a Saturday for physicians and nurses in the area and for all kinds of other people. It was a full house. It was such a great success that we decided to do more, and the next one we held downtown [Washington, DC] at the Hilton. I remember calling Ed [Dr. Edward] Brandt. Shelly Lengel was his information officer, and we'd cleared what we were going to do with her. She didn't see anything wrong with it, but she wasn't terribly optimistic. I was so pleased with the turnout and the questions that were coming off the floor after these presentations that I called up Dr. Brandt and asked him if he could come down to show his support to the community. He did come to the Washington Hilton. He was late—people were beginning to leave—but nonetheless, Ed Brandt did come.

That contract is still going, and the NIAID is still using it for outreach and education activities. We had meetings in Los Angeles, in Chicago, in [Washington] D.C., and, I think, in Miami. We hit about ten cities with the same kind of program. We modified it a little bit by putting on workshops, and we catered to specific interest groups. The goal was to get the truth out about AIDS, and to get rid of the myths associated with it. There were people being kicked out of restaurants, losing their jobs, because they were looked upon as lepers of sorts, who could pass the disease around. Physicians wouldn't work with them and ambulance drivers wouldn't pick up anybody whom they thought looked like an AIDS patient.

Rodrigues: One of the concerns of the early years was the safety of laboratory investigators working with an unknown pathogen. Was that an NIAID issue with which you were concerned?

Whitescarver: Certainly. Before we knew what the agent was, it was a real concern. But NIAID had worked with so many highly infectious and lethal agents that

working with the unknown AIDS pathogen just posed the problem of finding the best way to handle it. The first thing our scientists did was to handle it the same way they handled the hepatitis B virus.

Harden: Do you have Ken Sell's 1983 memo instructing that hepatitis precautions be taken? What did people do before 1983? Were there any special routines?

Whitescarver: Yes. We kept telling people to use very strict microbiological techniques in dealing with patients and their material. They had to treat it the same way they would hepatitis B. The reason we did that is because hepatitis B is so infectious that we thought it would provide protection if the AIDS virus turned out to be highly infectious also. Since the AIDS organism is not nearly as infectious as hepatitis B, it turned out to be a good precaution. We didn't think we were going to be dealing with anything of that scale. The epidemic certainly didn't parallel what one would expect in a far more infectious virus like the other ones they play with all the time around here. It just didn't seem to be that. AIDS wasn't as infectious, but it was, of course, highly lethal. Epidemiologically, AIDS seemed to be transmitted in a pattern like that of hepatitis B.

Rodrigues: One of the things that Dr. Richard Wyatt told us was that some investigators were concerned about introducing unknown AIDS specimens into the laboratory, not necessarily because of the risk to themselves but because they feared contamination of their existing cultures. For that reason, some labs were reluctant to look at these specimens and, perhaps, to initiate work on AIDS.

Whitescarver: No, I hadn't heard that, but I can understand. I studied Mycoplasma for my Ph.D. thesis. Everybody hated Mycoplasma, which were organisms they knew little about, because they got into tissue cultures and contaminated everything. So, I can see the reason for caution there.

Rodrigues: We'd like to round out your involvement with AIDS. When did you leave NIH?

Whitescarver: It was in 1984.

Rodrigues: Were you involved with AIDS at Emory University?

Whitescarver: No. After I got to Emory, and the year's service away from government had passed, I became a consultant to the contract that was doing some of these outreach activities. We tried to get AIDS activities going at Emory, but we never succeeded.

Harden: Would you comment on that? I have heard this from a number of people. Was this because of the conservatism of the Emory physicians?

Whitescarver: Not the physicians. The administration wanted nothing to do with AIDS. Then there was Grady [Henry Grady Memorial Hospital]. Grady is yet another story. Emory University Hospital agreed to take care of private patients with AIDS, but they were as sure as hell not going to cordon off any area and designate it as an AIDS area, because they believed that it would prevent patients from coming to Emory Hospital. They didn't want Emory recognized as an AIDS center. The Emory administration agreed that people could do basic research but discouraged anything having to do directly with AIDS patients, because they didn't want a stream of AIDS patients coming into the hospital. That was profound.

I can think of at least three attempts that we made to get something going in AIDS with support from the clinical investigators, who were very concerned. From my perspective as the dean for research, I always supported research that would bring money in to the university. I knew there was lots of money in AIDS. I was pretty well-connected to where the money was coming from, but the Emory administration preferred not to have the money. Even now, nothing is happening down there.

Harden: You said that Grady was another story.

Whitescarver: Grady's another story because as a city-county hospital, it happens to have a contract with the Emory medical staff to take care of patients. It is a training hospital. Grady does have lots of AIDS patients, as you would expect, but it's nil insofar as being an AIDS base. They don't have an AIDS clinic, even though they do see and take care of a lot of AIDS patients.

Rodrigues: For the record, when did you come back to NIH and what were the circumstances?

Whitescarver: I had visited Dr. Fauci on a couple of occasions when I came up to consult on the outreach contract. I would have dinner with him, and he would say something like, "Jack, you really should come back to Washington. You'd like it so much." And, I would say, "Tony, yes, I love Washington and I miss it desperately. But, I can't afford to come back to government, nor can you afford me." When he was appointed associate director for AIDS research—and when this office was being set up—he asked if I would come and consult. Actually, it was Mike [Michael] Goldrich who asked if I would come and consult on setting up the office. About the second time I came, Dr. Fauci said, "I need a deputy and I've been looking for a medical person." I think he'd been turned down twice. I know that

Richard Wyatt was offered the job, but he turned it down. He asked if I would I be interested in taking the job as deputy. Of course, I really was interested in AIDS again, and I was really getting frustrated at Emory. So, I said, "Well, keep me on a personal services contract for a little longer and we'll see." I came on full time in June.

Rodrigues: You've seen this organization grow up quite a bit in the last few years.

Whitescarver: Yes. The work load has grown since three or four people were handling it out of [Dr.] Jay's [Moskowitz] office. As to the policy aspects, we've taken on additional programs. We have now the loan repayment program, and we're starting to do regional meetings on something that was very poorly named: technology transfer. What that really means is taking new clinical information and getting it out to primary care and family care physicians. This is information such as how to take care of ARC [AIDS-related complex] and asymptomatic patients. We're going to do our first regional meeting—believe it or not—at Emory.

Harden: That's ironic, isn't it?

Whitescarver: HRSA wants to be involved, and we just met with HRSA representatives about collaboration and use of their education centers. They have twelve, I think, around the country. We will provide them resource information and speakers for their program. Things like this that we've taken on have brought a new level of effort to the office. We still have the same twenty-four hour turn-arounds from downtown, etc. to manage as well.

Harden: Do you have anything else that you wanted to add before we stop?

Whitescarver: No, but I'll help you track down that CIRID review. Have you talked to Nancy Brun?

Harden: Not yet.

Whitescarver: She actually wrote that report. I went on the site visit. She may have kept a copy. I didn't think that the AIDS presentation was something that we should put in that report. I saw that it was not relevant to the intent of that document. Nancy argued with me about that and since she wrote the report, it got in there. And, now, I'm very grateful that it did. But, it was she who got it in there. I didn't think that it was part of the document or had any relevance to the document.

Rodrigues: Are there any other names that come to mind of individuals who were involved at NIH?

Whitescarver: Have you talked to Ken Sell yet? Tom Quinn was involved in the very first development of Project SIDA, the Zaire project. He can certainly tell you about the cooperation with CDC. You've talked to Dr. Clifford Lane. Dr. Lane was here from the very beginning. Yvonne du Buy can give you a good story on how NIAID took the lead at the NIH, after the period when leadership was rocking between the NIAID and Cancer [NCI]. She was involved when Cancer turned the lead over to NIAID. I think there are documents to support that, if they, too, haven't disappeared. I can't think of anybody else in those early days who might be able to give some interesting things from an historical perspective. There were some bizarre things that folks looked into as possible causes of AIDS, such as fungus. Tom Quinn, bless his heart, thought for a while that maybe something from dogs caused it, because all the gay people had dogs.

Rodrigues: Some of the theories are fascinating. Art [Dr. Arthur] Levine told me one about tanning salons. Apparently, gay men had bronze tans, and they got them by going to tanning salons. Some people thought that maybe the radiation from the salons was wiping out their immune systems.

Whitescarver: It might be interesting to talk to Bill [Dr. William] Jordan, because he was head of the [NIAID] Microbiology and Infectious Diseases Program and certainly was involved in all the early activities.

Harden: We certainly appreciate your talking with us, Dr. Whitescarver.

Whitescarver: I'm delighted. I'm very anxious that this documentation project be completed.

###